The Cardiology Audit

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Objectives

• Understand the process of the audit.
• Gain knowledge of Cardiology Coding and Documentation Rules for auditing.

Phases Of the Audit

• Pre- Audit
  – Decide who will audit
  – Who will make selections
  – What phase of the billing cycle
• The Audit
  – Reviewing records, document findings
• Post-Audit
  – Prepare a summary
  – Educate
  – How will you monitor going forward
Pre-Audit

Know Your Client

- Who is requesting the audit?
- What are they hoping to find from the audit?
- Who will make selections?
- What type of Audit is being requested?
  - Random
  - Focused

Who Will Audit

- Internal Auditor
  - Less expensive
  - May be biased
  - Potentially, no time constraints
- External Auditor
  - An expense to the practice
  - Attorney/Client Privilege
  - Physician buy in
Determine Phase For Audit

• Pre-billing or Prospective
  – Catching errors before they go out
  – No need to return monies
  – May effect cash/business flow

• Paid or Retrospective

Pre-Audit

• Contracting
  – Sign a business agreement
  – Set pricing
    • Per chart
    • Per hour
    • Will there be a legal retainer
    • Will it be a bulk “project” fee

Pre-Audit

• Sample Selection
  – Time period to be covered
    • 3-6 months
    • A year
  – Recommend a minimum of 10 charts per provider
    • Considerations for this determination might be:
      – An already identified problem
      – Follow-up audit
Scope Of Audit

• What will be reviewed in the audit?
  – EM
  – Diagnosis Coding
  – Surgery
  – Modifier usage
  – Incident to
  – Is this physician practice, hospital in or out patient
  – Is this a teaching facility

HIPAA

• How will you obtain records
• Will the records be scrubbed
• PHI transmissions
  – Passwords
  – logins

The Audit
Tools of the Auditor

- CPT books for year you are auditing
- ICD-9/10
- CCI edits
- Anatomy charts/books
- Coders Desk Reference
- CPT assistant
- Internet
- Specialty Coding Books/Tools
- Physicians

Heart Anatomy

The Audit

- Taking a look
  - Coding accuracy
  - Diagnosis linking with documentation
  - Modifier usage
  - PATH rules
  - Incident to rules
  - Global periods
  - Orders for studies
The Audit

• Are ABN’s on file
• Is there a signature log to identify providers
• Were there codes missing from the bill that were done

The Audit

• What will you look for
  – Date of Service on all entries
  – Medical record number/name matches
  – Signature
    • E sign
    • Hand signature
  – Patient identified on each page
  – Can you tell the author on note

Document Your Findings

• How will you do this?
• Is there an audit sheet that the client wants you to use?
• Spreadsheet
• Document all issues, making the client aware of all issues helps them in the long run.
The Audit Grid

E/M

• 95 or 97 Guidelines
  – Don’t just assume everyone uses the ‘95 guidelines
  – Look at both when auditing to give the practice the benefit of the audit
  – Ensure that you as the auditor know the ‘97 guidelines

97 Documentation Requirements for Cardiology Exam

Content and Documentation Requirements

• Problem Focused - **One to five** elements identified by a bullet.
• Expanded Problem Focused - **At least six** elements identified by a bullet.
97 Documentation Requirements for Cardiology Exam

- **Detailed** - At least twelve elements identified by a bullet.
- **Comprehensive** - Perform all elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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**E/M**

- Are the elements there?
  - Is there CC or just “here for follow-up”?
  - Is there HPI or is it just a system review?
  - Was an exam done? Does there need to be one?
  - Medical Decision Making, how complex?
- Was time used?
  - If so, was it reported correctly?
  - Was the counseling or coordination of care documented?

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**EKG**

- How many leads – is this stated?
  - Code 93000 states at least 12 leads
  - Is the entire piece documented or is it tracing only or just interpretation and report
  - Can you tell what was done by the documentation
Cardiology 2013

Cardiography
93000 - 93042

Only changes are to CPT descriptions. The codes no longer specify “physician” supervision.

Please remember.
There must be a specific order for a study followed by separate, signed, written and retrievable report.

Echocardiography

• Approach –
  – Transthoracic
  – Trans esophageal
• Complete or Follow up
• Is color flow documented?
• Is there stress by drug or treadmill documented?

Cardiac Catheterization

• Can you follow the catheter?
• Is there selective catheterization documented appropriately?
• Do you, as the auditor, understand the new hierarchy coding of PCI?
• Do you understand when you can bill diagnostic with PCI?
Cardiology 2013

Modeled after the lower extremity revascularization codes...using the anatomy of the heart...created distinct groups

- 5 major coronary arteries (left main, left anterior descending, left circumflex, right, ramus intermedius)
  - Report up to two interventions in branch vessels with add-on codes
    - The left main and ramus intermedius do not have recognized branches for reporting purposes

For Percutaneous Coronary Interventional (PCI) Procedures

- Interventions in a major vessel itself (including proximal, mid, and distal vessel) are reported with one PCI code (report the highest service level of intervention performed)
- Interventions in up to 2 branches of each major vessel may be reported with add-on codes (LAD diagonals, circumflex marginals, etc.)

The result of the restructuring is the following code selections

- Balloon angioplasty alone (92920, +92921)
- Stent alone (92928, +92929)
- Atherectomy alone (92924, +92925)
- Atherectomy+stent (92933, +92934)
- Any PCI of or through a coronary bypass graft (includes distal protection) (92937, +93938)
- Any PCI of acute/subacute occlusion during acute MI (92941)
- Any PCI of chronic total occlusion (92943, +92944)

All include balloon angioplasty when performed

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The intent is to report only one base code and the selection is based on which procedure is the most work intensive based on the following...

1. Acute total occlusion = chronic total occlusion - (most work)
2. Atherectomy + stent
3. Atherectomy without stent
4. Stent
5. Any service through a bypass graft
6. Balloon angioplasty alone
(based upon CMS valuations)

Other Guidelines offered from CPT

• If a single lesion extends from one target vessel (major coronary artery, graft, or branch) into another target vessel but can be revascularized with a single intervention bridging the two vessels, report with a single code (eg, LAD into diagonal, LM into LAD)
• For bifurcation lesions (when both treated), report for both vessels (eg, LAD and LAD diagonal)

New reporting instructions from the guidelines

• Do not report pharmacologic administration +93463 in conjunction with PCI (92920-92944) or with coronary thrombolysis (92975, 92977)
• Injection for pulmonary angiography (+93568) may be reported with right heart catheterization codes 93451, 93453, 93456, 93457, 93460-93461, 93530-93533
• When aortography is performed with other cardiac catheterization procedures, report +93567 for supravalvular aortography and the radiological supervision and interpretation code (36221, 75600-75630) for non-supravalvular thoracic or abdominal aortography
Electrophysiology Procedures

- Deletion of intracardiac catheter ablation codes 93651 and 93652
- 5 new codes (93653-93657) differentiating ablation techniques for:
  - Supraventricular arrhythmias
  - Ventricular arrhythmias
  - Pulmonary vein isolation (for atrial fibrillation)
  - Ablation of discrete mechanism of arrhythmia separate from the primary ablated mechanism
  - Additional linear or focal ablation for mechanism of atrial fibrillation remaining after pulmonary vein isolation

Local Coverage Determination

- A searchable Coverage Database
  - Allows users to search both the NCD and LCD databases
  - Use keyword, diagnosis/procedure, and date
    - Indexes – pre-defined lists
    - Reports - reports of National and Local Coverage data
    - Downloads - download complete sets

Modifiers

- Are they used
- Are they applied appropriately
  - 26
  - 22
  - 59
  - GC
  - GE
New Modifier

RI – Ramus Intermedius
anomaly, possible branch of the Left Main. Instead of bifurcating into the LAD & LCX, it trifurcates LAD, LCX and RI

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NCCI

Diagnostic and therapeutic cardiovascular procedures
Medicine Section – Code range 92950-92998, 93451-93533, 93600-93624, 93640-93657
– HCPCS/CPT codes describing radiologic supervision and interpretation for specific interventional vascular procedures may be separately reportable.

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Cardiac output measurements

- CPT codes 93561-93562
  - Per CPT instruction, CPT codes 93561-93562 should not be reported separately with cardiac catheterization codes

Cardiac Rehab Services

- CPT codes 93797 and 93798
  - describe comprehensive services
  - codes include all services necessary for cardiac rehabilitation
  - E&M codes should not be reported separately unless a significant, separately identifiable E&M service is performed and documented in the medical record.
  - report the E&M service with modifier 25

Cardiac Stress Test

- Obtains a history and performs a limited physical examination related to the cardiac stress test, NOT billable.
  - ONLY billable if separately identifiable E&M service is performed
  - Then bill with -25
Microvolt T-wave alternans (MTWA)

• CPT code 93025 - testing requires a submaximal stress test that differs from the traditional exercise stress test

• CPT codes 93015-93018 should not be reported separately for the submaximal stress test integral to MTWA testing
  – UNLESS a physician performs an MTWA with submaximal stress test followed by a period of rest and then a traditional stress test on the same date of service, both the MTWA and traditional stress test may be reported separately

Pacemaker/Pacing Cardioverter-Defibrillator & Intracardiac Electrophysiology procedures

• Although these procedures require intravascular placement of catheters into coronary vessels or cardiac chambers under fluoroscopic guidance, Physicians should NOT report cardiac cath or selective catheterization codes.

• Report no Fluro or Ultrasound codes other than 71090 (fluoroscopy during insertion of a pacemaker)

Post-Audit
Post-Audit

• Prepare a final report
  – Show areas of concern
  – Calculate error rate
  – Identify error patterns
  – Identify areas that need re-pay/education
  – Back up wrong findings
    • Compare what they coded to what was actually documented
  – Allow the client to refute

Post-Audit

• Educate

Post-Audit

• Meet with Provider
  – On site or phone call
  – Physicians/Coders or Both
  – Give tools to help them improve
    • Give examples
    • Explain rationale
  – As much as possible back up with guidelines, websites, specialty books etc..

Post-Audit

• Allow opportunity for discussion
  – Give the provider and opportunity to explain their side/reason for coding as they do.
  – As much as possible stay away from your “opinion” and try to back it up in writing
  – In the end it is their decision to adjust or decide what they will do going forward
Post Audit

- What are their needs/desires going forward
  - Develop training plan for coders/physicians
    - One on one, small groups
    - Will it be focused based on areas of concern
    - Who will be included
      - Physicians
      - Coders
      - Nurses
      - Business office staff

Getting A Game Plan

- What's next
  - Time frame to re-audit
  - Templates
  - Cheat sheets
  - Further education

Lets Audit some Notes!
Questions??
Thank You!!!
DAL

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